recipients, their families or any other third party.

1-7 RIGHT TO A HEARING

Within thirty (30) calendar days after the date of the notice from the Director of the Division of Medicaid of the intent to sanction, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forth the facts which the provider contends places him in compliance with the Division of Medicaid's regulations or his defenses thereto.

Suspension or withholding of payments may continue until such a time as a final determination is made regarding the appropriateness of the claims or amounts in question.

Unless a timely and proper request for a hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination.

The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the Division of Medicaid.

1-8 OVERPAYMENTS AND UNDERPAYMENTS

An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is proper. Overpayments must be repaid to the Division of Medicaid within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the Division of Medicaid first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the Division of Medicaid in writing, whichever date is earlier.

Failure to repay an overpayment to the Division of Medicaid may result in sanctions as described in Section 1-6 above.

An underpayment occurs when an amount which is paid by the Division of Medicaid to a provider is less than the amount that is proper. Underpayments will be reimbursed to the provider within sixty (60) days after the date of discovery.

1-9 FINAL AUDIT FOR TERMINATING PROVIDER

Each provider will advise the Division of Medicaid prior to terminating his/her participation in the program, or the sale of a center. A final audit of the center will be conducted as soon as

possible after the final date of participation or sale. This will allow the Division of Medicaid to insure that a proper final payment is made to the organization terminating his participation or selling his center.

1-10 ASSURANCE OF PAYMENT

The State will pay a FQHC with a valid provider agreement, furnishing services in accordance with these and other regulations of the Mississippi Medical Assistance Program in accordance with the requirements of applicable State regulations and Federal law and amounts determined under this plan. Established payment rates will be adequate to reimburse the actual allowable costs of each center. At the close of each reporting period, cost settlement will ensure reimbursement of 100% of reasonable costs for providing services to Medicaid patients.

1-11 ACCEPTANCE OF PAYMENT

Participation in the Title XIX Program will be limited to those centers which agree to accept the Division of Medicaid's payment as payment in full for all covered services provided to Medicaid recipients.

1-12 REQUESTS FOR A RATE CHANGE

A FQHC may appeal its prospective rate for core services to the Division of Medicaid under the following circumstances:

A. Allowable cost exceeds the Medicaid prospective rate due to the following:

1) The addition of new and necessary services;

2) The addition of capital assets or improvements;

3) Extraordinary circumstances which may include riot, strike, civil insurrection, earthquakes, or flood;

B. The Medicaid prospective rate exceeds allowable cost.

A request for a change in the prospective rate will be considered only when a rate change of at least 10% would occur as a result of the change. The request must be submitted in writing to the Division of Medicaid. The request should clearly identify the grounds of the appeal and the dollar amount in question and should include copies of documenting support for the appeal. The center should make every effort possible to ensure that requests which do not meet the above criteria are not submitted.

CHAPTER 2

STANDARDS FOR ALLOWABLE COSTS

The standards listed below are established to provide guidance in determining whether certain selected cost items will be recognized as allowable costs. Allowable costs must be compiled on the basis of generally accepted accounting principles. Allowable costs are based on HIM 15 standards except as otherwise described herein.

2-1 ALLOWABLE COSTS

Allowable costs means costs that are incurred by a center and are reasonable in amount and proper and necessary for the efficient delivery of FQHC services. The purchase or rental by a center of any property, plant equipment, services, supplies, etc., will not exceed the cost that a prudent buyer would pay in the open market to obtain these items.

A. Generally, the following types and items of cost will be included in allowable costs of core services to the extent that they are covered by the State Medicaid Plan and are reasonable:

1. Compensation for the services of physicians, nurse practitioners, certified nurse midwives, specialized

nurse practitioners, visiting nurses, qualified clinical psychologists, and clinical social workers employed by the center.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies incident to the services of a physician, nurse practitioner, certified nurse midwife, specialized nurse practitioner, qualified clinical psychologist, or clinical social worker.

4. Overhead Costs, including center administration, costs applicable to use and maintenance of the center building and depreciation costs. The overhead costs directly related to patient care should be expensed in the "Core Health Care Costs" cost center of the cost report. Examples of overhead costs which are directly related to patient care are depreciation expense related to examination equipment and malpractice liability insurance premiums apportioned as set forth in CFR 413.56(a) and (b). Overhead cost indirectly related to patient care should be reported in the "Clinic Overhead Costs" cost center of the cost report.

5. Costs of services purchased by the center.

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B. For non-core services (other ambulatory services) provided by the FQHC, the following types and items of cost will be included in allowable costs to the extent they are covered by the State Medicaid Plan and are reasonable.

1. Compensation for the services of qualified providers of other ambulatory services; including pharmacists, dentists, optometrists, and their assistants. Compensation of providers of Early Periodic Screening and Diagnostic Testing (EPSDT) treatment services will be covered as an "other ambulatory service" cost to the extent that they are not covered as a core service provider.

2. Costs of services and supplies incident to the other ambulatory services allowed by the Mississippi State Medicaid Plan.

3. Overhead Costs, including center administration, costs applicable to use and maintenance of the center building and depreciation costs. Only overhead costs directly related to patient care should be included in the "Other Ambulatory Services" cost center of the cost report. Examples of overhead costs which are directly related to patient care are depreciation expense related to

examination equipment and malpractice liability insurance premiums apportioned as set forth in CFR 413.56(a) and (b). Overhead costs indirectly related to patient care should be reported in the "Clinic Overhead Costs" cost center of the cost report.

4. Costs of services purchased by the center.

C. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider; by common ownership of 5% or more equity, control, interlocking directorates, or officers; are allowable at the cost to the related organization. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. These requirements apply to the sale, transfer, lease-back or rental of the property, plant or equipment or purchase of services of the related organization.

Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in the Provider's Reimbursement Manual, SSA-HIM-15, Chapter 10 and Section 2150.3.

In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other.

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the fiscal agent and/or the Division of Medicaid:

1) That the supplying organization is a bona fide separate organization;
2) That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market.

D. Specific guidelines for allowability of selected costs follows:

1. Interest Expense. Interest charges, finance charges and other costs related to property acquisition and interest and other related cost on current and capital indebtedness are allowable cost. Loans which result in excess funds or investments are not allowable costs. Interest applying to mortgages on the property and plant of the facility will be included in allowable costs. Interest incurred on a loan made for a purpose reasonably related to patient care will be included in allowable costs. Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made will be recognized. In no case will allowable costs for interest exceed limitations set by State law.

2. Depreciation Expense. An appropriate allowance for depreciation on buildings and equipment, of which the center is the record title holder, used to provide covered services to medical assistance recipients is an allowable cost subject to the following conditions.